



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative

Box Number 15

MFDR Tracking Number

M4-10-5061-01

MFDR Date Received

August 6, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our doctors usually spend 45-60 minutes conducting a [sic] an evaluation of new patients. As noted in the typed subsequent report that was submitted with the HCFA billing, you can clearly note that a detailed history is documented under Present Medical Condition on our follow-up exam form. A detailed examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of low complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations."

Amount in Dispute: \$265.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Re: 99204: The level of E&M code billed (99204) was not supported by the documentation submitted. The submitted documentation did not meet the key components for billing a level 99204, lacking clear decision making, and was best described as a level 99203. Re: 99080: Allowance was per Bill Review/System Pricing at fee schedule."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2010	99204	\$250.00	\$0.00
February 22, 2010	99080-73	\$15.00	\$2.25
		\$265.00	\$2.25

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 150 – Payer deems the information submitted does not support this level of service
- 850-203 – The level of E&M code submitted is not supported by documentation \$0.00
- 900-030 – This charge was reviewed through the clinical validation program fee arrangement
- 100 – Any network reduction is in accordance with the Network
- 113-001 – Network import re-pricing-contracted provider
- W1 – W Workers Compensation State Fee Schedule Adjustment
- 850-107 – Initial allowance recommended in accordance with the state fee schedule guidelines. \$232.03.
- 905-005 – The documentation attached supports treatment to the workers compensation injury

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate
2. Did the insurance carrier issue payment pursuant to 28 Texas Administrative Code §129.5 for CPT code 99080-73?
3. Did the requestor submit documentation to support the level of service billed for CPT code 99204?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement" and "100 – Any network reduction is in accordance with the Network." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 30, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §129.5 "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

The requestor seeks reimbursement for CPT code 99080-73 in the amount of \$15.00. Review of the EOB dated April 5, 2010 supports that the insurance carrier issue payment in the amount of \$12.75, therefore the requestor is entitled to an additional reimbursement in the amount of \$2.25.

3. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor disputes non-payment of CPT code 99204 defined by the AMA CPT Code book as follows "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

Review of the requestors' submitted documentation finds that the requestor does not meet the documentation requirements for the billing of CPT code 99204. As a result, reimbursement cannot be recommended for CPT code 99204.

4. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT code 99204, however is entitled to an additional reimbursement in the amount of \$2.25 for CPT code 99080-73.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2.25.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2.25 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>October 31, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.